



MANAGED CARE ANNUAL STATISTICAL REPORT

Published March 2000

Internet Homepage - <http://www.dhs.ca.gov/MCSS>

The Managed Care Annual Statistical Report provides information about the managed care programs rendering care to Medi-Cal beneficiaries. It provides information on the number of persons enrolled in managed care, and a description of some of the demographic and eligibility characteristics of this population.

Prepared by the Department of Health Services.

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STATISTICAL REPORT
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Introduction

The Managed Care Annual Statistical Report provides information about the medical managed care programs rendering care to Medi-Cal eligibles. It provides information on the number of persons enrolled in managed care and a description of some of the demographic and eligibility characteristics of this population.¹ Data included in this report are generally through July 1999, and thus changes in the managed care program since then are not reflected here.

The Managed Care Annual Statistical Report does not provide cost or utilization information for the Medi-Cal managed care population. Cost data for this population, as well as those in fee-for-service, are available in the Annual Statistical Report issued by this Section. Managed care utilization information is currently limited, but may become available at a future date from the State Department of Health Services (DHS). Detailed information about dental managed care can be obtained from the DHS Payment Systems Division, Office of Medi-Cal Dental Services.

This report is comprised of three Sections, each of which describe the managed care program and its population in the broader context of the whole medical Medi-Cal program. These Sections are: 1) current enrollment data; 2) demographic characteristics; and, 3) eligibility continuity and rate of new eligibles.

The Managed Care Annual Statistical Report provides slightly different material each year: most of the tables and charts are merely updated, but some are presented in a slightly different fashion, whereas others are entirely new. A current description of the history and types of managed care contracts is available in the Managed Care Annual Statistical Report published in March 1998. This report and the one published in April 1999 are available on the Internet at <http://www.dhs.ca.gov/MCSS/>. As indicated in the March 1998 report, some managed care contract capitation rates are publicly available; these can be found on the Internet at <http://www.dhs.ca.gov/mcs/mcmcd/>.

¹ The terms “eligible,” “beneficiary,” and “enrollee” are used interchangeably within Medi-Cal. Each refers to a person who meets all requirements for receiving a Medi-Cal medical service or good (e.g., drugs, DME items) and is enrolled in the Medi-Cal program. These terms are in contrast to the term “user,” who instead is an eligible/beneficiary/enrollee actually using a service or receiving a drug, DME item, etc.

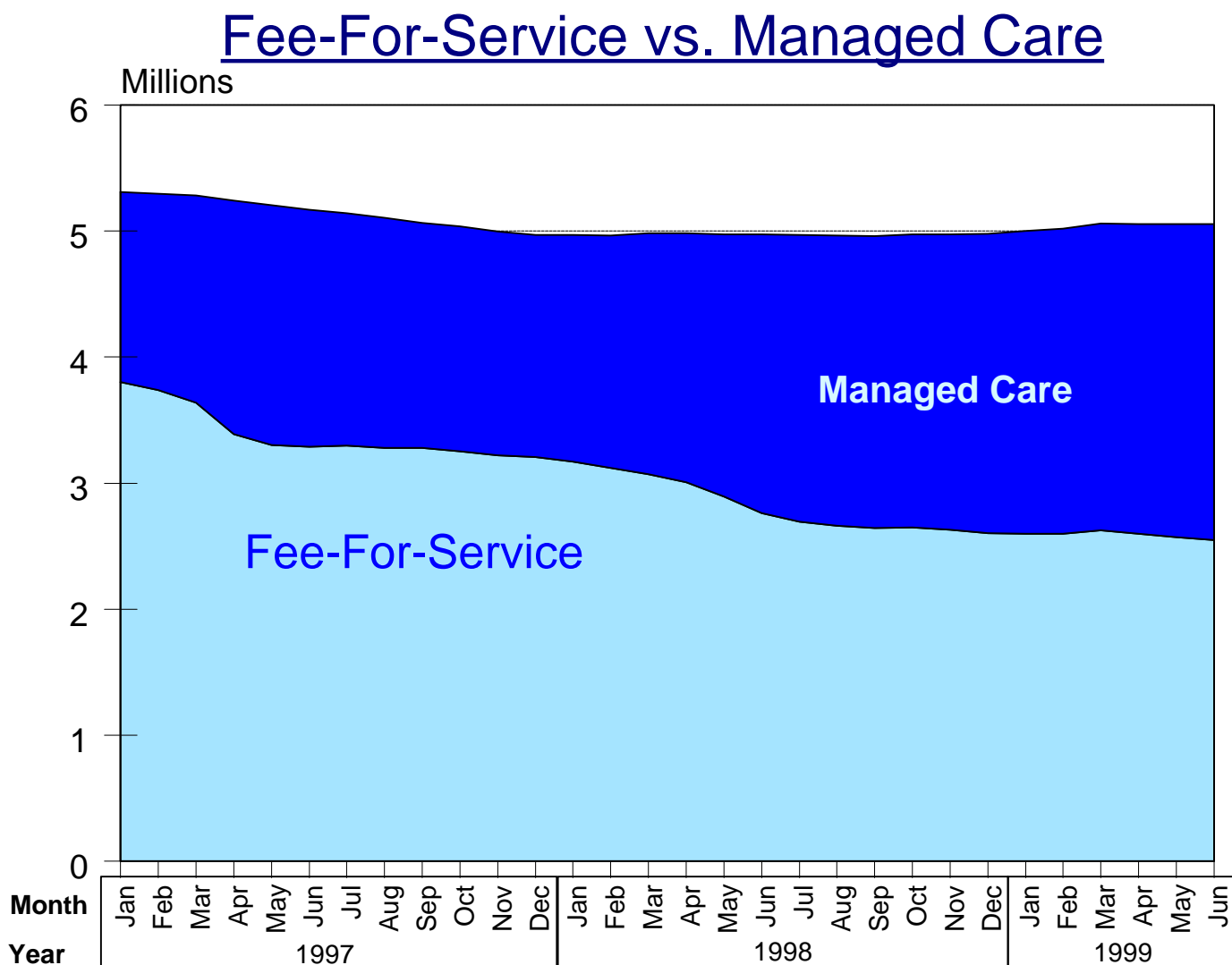
Section 1, Current Enrollment Data

Tables 1.1A, Medi-Cal Eligibles by Program - Fee-For-Service vs. Managed Care



The following graph shows the monthly enrollment in Medi-Cal for medical fee-for-service and managed care, from 1997 forward. Total June 1999 enrollment was 2,507,764 for Managed Care and 2,548,007 for Fee-For-Service.

(Note: PCCM eligibles are included under Managed Care in this table.)



Tables 1.1B, Medi-Cal Eligibles by Program -Managed Care Programs

FFS-covered eligibles are excluded from this graph. Each type of managed care program is shown separately. . Total June 1999 enrollment was: Two Plan - 1,802,982; COHS - 362,454; GMC - 330,514; PHP - 9,626; PCCM - 2,188.

Managed Care Programs

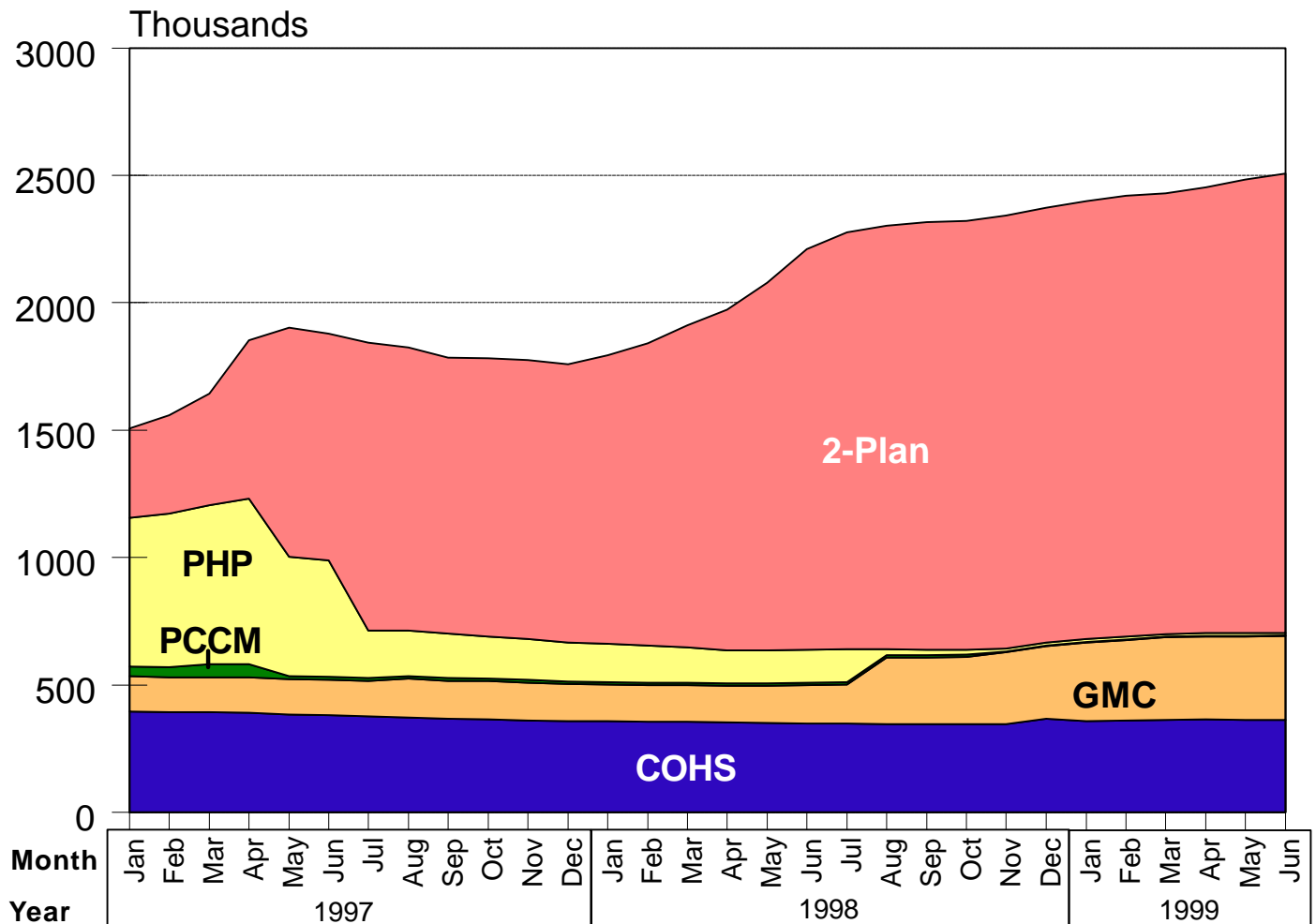


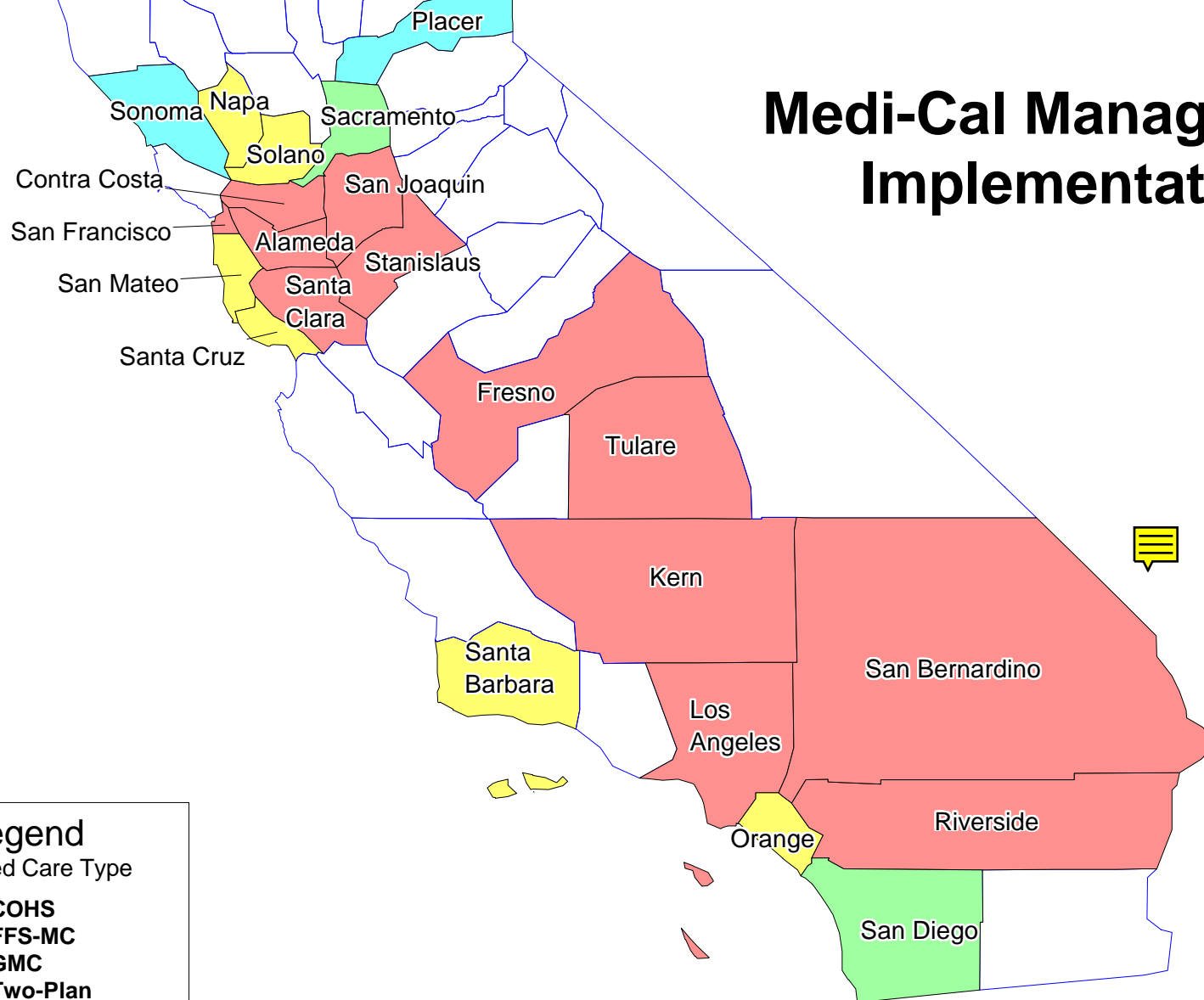
Table 1.2, Map of California's Managed Care Counties

The following map of California shows each county with a managed care plan in operation.

(Note: Excludes PHP and PCCM programs.)

[Click here to view Table 1.2 Map.](#)

Medi-Cal Managed Care Implementation



Legend

Managed Care Type

- COHS
- FFS-MC
- GMC
- Two-Plan

Table 1.3, Major Managed Care Plans, by County

The following tables show Medi-Cal managed care plans by California county. The managed care programs covered are: County Organized Health Systems (COHS), Fee-For-Service Managed Care Network (FFS-MCN), Geographic Managed Care (GMC), and Two-Plan. Excluded are Prepaid Health Plan (PHP), Primary Care Case Management (PCCM), and special projects (e.g., AIDS, SCAN).

[Click here to view Table 1.3A](#)

Table 1.3A, Major Managed Care Plans by County

County	Program	LI/ CP	Plan Name	Start Date	Enrollment* as of Jul 99
Alameda	2-PLAN	LI	Alameda Alliance for Health	1/96	77,948
		CP	Blue Cross of California	7/96	29,434
Contra Costa	2-PLAN	LI	Contra Costa Health Plan	2/97	41,447
		CP	Foundation Health Plan (thru 5/98)	3/97	
		CP	Blue Cross of California	6/98	5,837
Fresno	2-PLAN	CP	Health Net	1/97	21,784
		CP	Blue Cross of California	11/96	105,464
Kern	2-PLAN	LI	Kern Health Systems	7/96	49,064
		CP	Blue Cross of California	9/96	27,619
Los Angeles	2-PLAN	LI	LA Care Health Plan	4/97	614,988
		CP	Health Net	7/97	410,106
Napa	COHS		Partnership Health Plan of Calif.	3/98	8,339
Orange	COHS		CalOPTIMA	10/95	217,713
Placer	FFS/MCN**		Placer County Managed Care Network	10/97	12,297
Riverside	2-PLAN	LI	Inland Empire Health Plan	9/96	74,890
		CP	Molina Medical Centers	3/98	17,104
Sacramento	GMC		Blue Cross of California	4/94	50,333
			Health Net	5/96	24,890
			Kaiser Foundation	4/94	19,121
			Maxicare	6/98	18,394
			OMNI Healthcare	4/94	24,858
			Western Health Advantage	5/97	15,037
San Bernardino	2-PLAN	LI	Inland Empire Health Plan	9/96	87,373
		CP	Molina Medical Centers	3/98	20,307
San Diego	GMC***		Blue Cross of California	7/98	10,435
			Community Health Group	7/98	75,229
			Health Net	7/98	8,251
			Kaiser Foundation	7/98	9,097
			Sharp Health Plan	7/98	48,479
			UCSD Healthcare	7/98	14,073
			Universal Care	7/98	14,016

Table 1.3A, Major Managed Care Plans by County (continued)

County	Program	LI/ CP	Plan Name	Start Date	Enrollment* as of Jul 99
San Francisco	2-PLAN	LI	San Francisco Health Plan	1/97	21,822
		CP	Blue Cross of California	7/96	14,452
San Joaquin	2-PLAN	LI	Health Plan of San Joaquin	2/96	52,375
		CP	OMNI Healthcare (thru 9/99)	1/97	12,951
San Mateo	COHS		Health Plan of San Mateo	12/87	40,333
Santa Barbara	COHS		Santa Barbara Regional Health Authority	9/83	40,177
Santa Clara	2-PLAN	LI	Santa Clara Family Health Plan	2/97	43,598
		CP	Blue Cross of California	10/96	28,342
Santa Cruz	COHS		Central Coast Alliance for Health	1/96	21,175
Solano	COHS		Partnership Health Plan of Calif.	5/94	42,129
Sonoma	FFS/MCN**		Sonoma County Managed Care Network	3/97	26,171
Stanislaus	2-PLAN	LI	Blue Cross of California/SLI	10/97	26,641
		CP	OMNI Healthcare (thru 9/99)	2/97	19,336
Tulare	2-PLAN	LI	Blue Cross of California	3/99	27,576
		CP	Health Net	2/99	4,712

* Source for number of eligibles for all plans except FFS/MCN is the Monthly Medi-Cal Eligibility File.

** Source for FFS/MCN eligible counts is the Monthly Enrollment Report provided by the Managed Care Fiscal Monitoring Unit.

*** Healthy San Diego.

Table 1.3B, Major Managed Care Plans by County

Plan Name	Program	LI/CP	County
Alameda Alliance for Health	2-PLAN	LI	Alameda
Blue Cross of California	2-PLAN	CP	Alameda
	2-PLAN	CP	Contra Costa
	2-PLAN	CP	Fresno
	2-PLAN	CP	Kern
	GMC		Sacramento
	GMC		San Diego*
	2-PLAN	CP	San Francisco
	2-PLAN	CP	Santa Clara
	2-PLAN	LI	Stanislaus
	2-PLAN	LI	Tulare
CalOptima	COHS		Orange
Community Health Group	GMC		San Diego*
Contra Costa Health Plan	2-PLAN	LI	Contra Costa
Health Net	2-PLAN	CP	Fresno
	2-PLAN	CP	Los Angeles
	GMC		Sacramento
	GMC		San Diego*
	2-PLAN	CP	Tulare
Health Plan of San Joaquin	2-PLAN	LI	San Joaquin
Health Plan of San Mateo	COHS		San Mateo
Inland Empire Health Plan	2-PLAN	LI	Riverside
	2-PLAN	LI	San Bernardino
Kaiser Foundation	GMC		Sacramento
	GMC		San Diego*
Kern Health Systems	2-PLAN	LI	Kern
LA Care Health Plan	2-PLAN	LI	Los Angeles
Maxicare	GMC		Sacramento

Table 1.3B, Major Managed Care Plans by County (continued)

Plan Name	Program	LI/CP	County
Molina Medical Centers	2-PLAN	CP	Riverside
	2-PLAN	CP	San Bernardino
OMNI Healthcare	GMC		Sacramento
	2-PLAN	CP	San Joaquin
	2-PLAN	CP	Stanislaus
Partnership Health Plan of Calif.	COHS		Napa
	COHS		Solano
Placer County Managed Care Network	FFS/MCN		Placer
San Francisco Health Plan	2-PLAN	LI	San Francisco
Santa Barbara Health Authority	COHS		Santa Barbara
Santa Clara Family Health Plan	2-PLAN	LI	Santa Clara
Santa Cruz County Health Org.	COHS		Santa Cruz
Sharp Health Plan	GMC		San Diego*
Sonoma County Managed Care Network	FFS/MCN		Sonoma
UCSD Healthcare	GMC		San Diego*
Universal Care	GMC		San Diego*
Western Health Advantage	GMC		Sacramento

* Healthy San Diego.

**Table 1.4, Aid Category Groups by FFS and Managed Care –
Sacramento GMC, Two-Plan, and COHS Counties**

The following pie chart shows the distribution of Medi-Cal beneficiaries broken out by managed care enrollment vs. fee-for-service and mandatory vs. voluntary/other aid category group, for counties partially or fully implemented to managed care as of July 1999. (See Table 1.5 for a list of these counties.) The aid categories generally comprising the groups labeled in the chart below as “Mandatory” and “Cal-Works, etc” are Cal-Works, medically needy, and medically indigent. As this indicates, the percent of those in managed care is 57.4% for all aid categories; this is an increase of almost 5% since July 1998 (see the Managed Care Annual Statistical Report published April 1999, available on the Internet at <http://www.dhs.ca.gov/MCSS>). (See Appendix, Table A.1 for definitions of the aid category groupings.)

Source of these data is the July 1999 month of eligibility Medi-Cal Eligibles File using a four-month lag.

Eligibles in Fee-For-Service and Managed Care
Percent Mandatory (CalWorks, etc.) vs.
Voluntary/Other (Non-CalWorks, etc.)
Medi-Cal Managed Care Counties

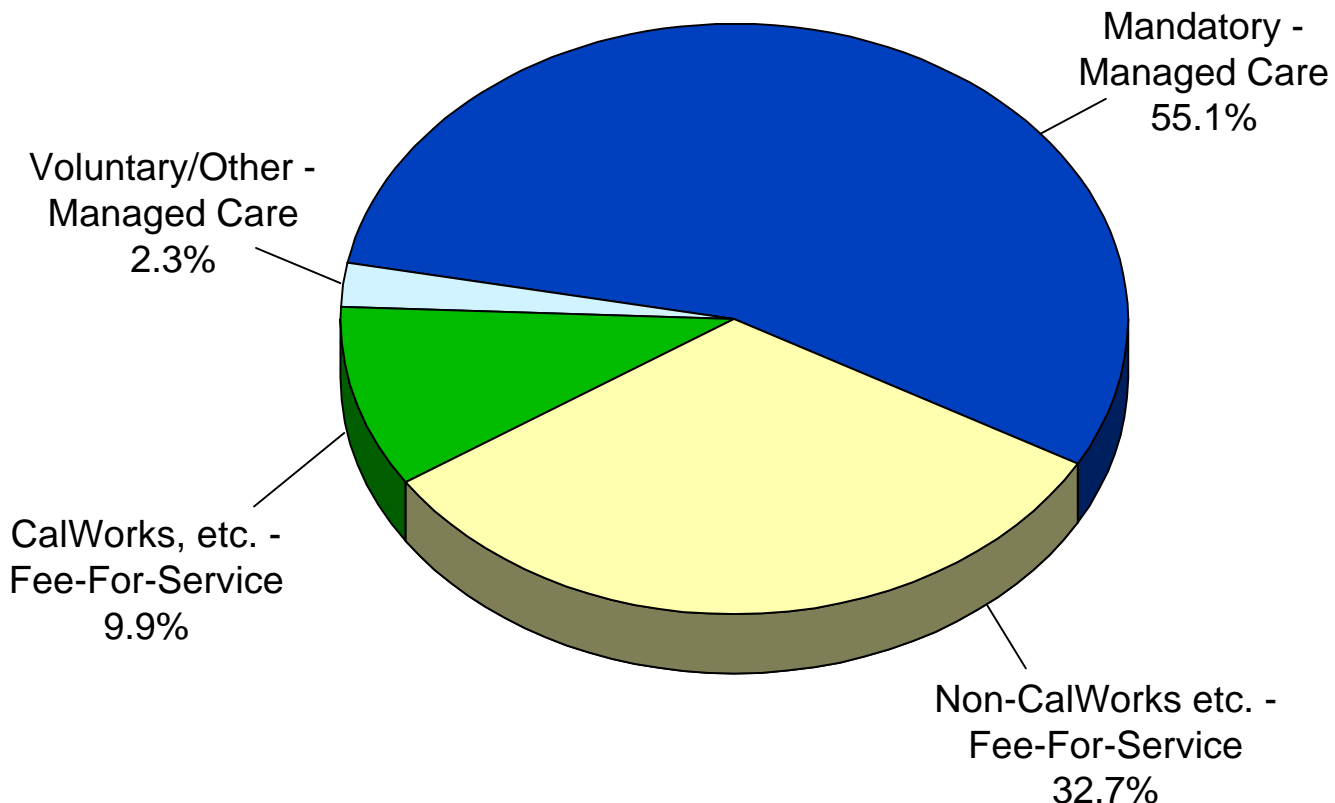
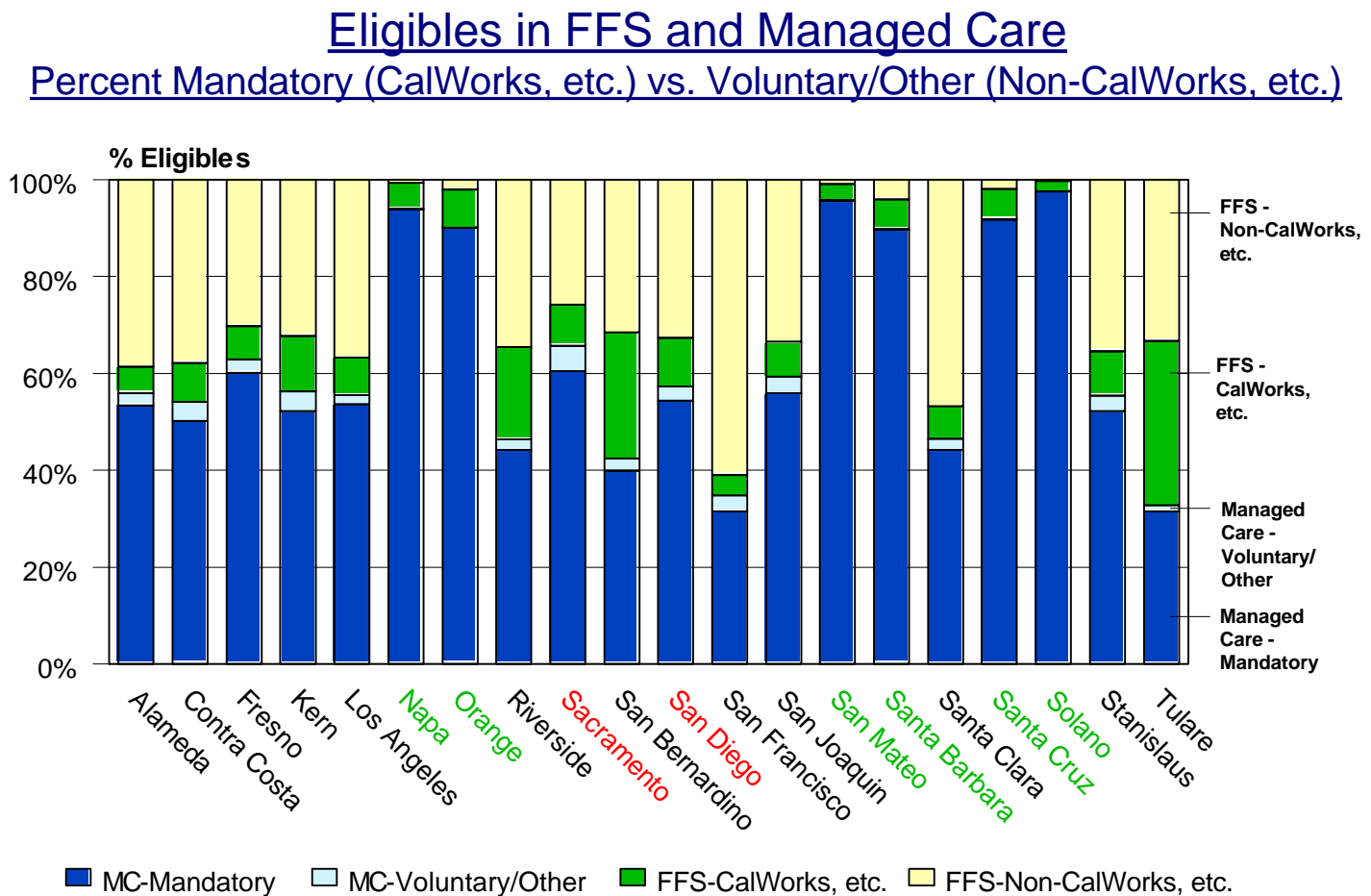


Table 1.5, Aid Category Groups by FFS and Managed Care – Sacramento GMC, Two-Plan, and COHS Counties

The following bar chart provides the distribution of Medi-Cal beneficiaries broken out by managed care enrollment vs. fee-for-service and mandatory vs. voluntary/other aid category group, for counties partially or fully implemented to managed care as of July 1999. As the chart shows, in most counties over half of these beneficiaries are in managed care. Note also that in the COHS counties, over 90% of the beneficiaries are in managed care. (See [Appendix, Table A.1](#) for definitions of the aid category groupings.)

Source of these data is the July 1999 month of eligibility Medi-Cal Eligibles File using a four-month lag.



Two-Plan: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare counties.

COHS: Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, and Solano counties.

GMC: Sacramento & San Diego counties.

Table 1.6, Percent Mandatory Eligibles in Managed Care of All Mandatory Eligibles, Two-Plan Model Counties Only

Of those eligibles in a mandatory aid category, the following chart shows the percent of those actually enrolled in a managed care plan. The average by county enrollment of mandatory aid code eligibles in the Two-Plan Model and Geographic Managed Care Counties has increased for implemented counties since July 1998 (see the Managed Care Annual Statistical Report published April 1999, available on the Internet at <http://www.dhs.ca.gov/MCSS>). The month of eligibility for these data is July 1999 month of eligibility, using a four-month lag. (Note: Riverside, San Bernardino, and Tulare counties were not fully implemented as of July 1999.)

The percent of those in a mandatory aid category is always less than 100%. This is because, even though a beneficiary is in a mandatory aid category, they will not necessarily end up in a managed care plan. Reasons for this include: 1) managed care implementation is still in process; 2) the beneficiary received Medi-Cal eligibility retroactively (that is, between the start of the eligibility month and up to four months later); 3) the beneficiary has other health coverage (usually, CHAMPUS, Medicare HMO, Kaiser, or some PHP/HMO and EPO coverage) that excludes them from enrolling in a plan; 4) the beneficiary just became eligible for Medi-Cal in a particular county, and is still in the process of selecting a plan or will be defaulted into one; 5) the beneficiary lives in an exempted zip code; 6) the beneficiary has a medical exemption granted by the DHS. For a complete list of these exemptions, contact the DHS Medi-Cal Managed Care Division.

Two-Plan Model and
Geographic Managed Care Counties Only
Percent Mandatory Eligibles
In Managed Care

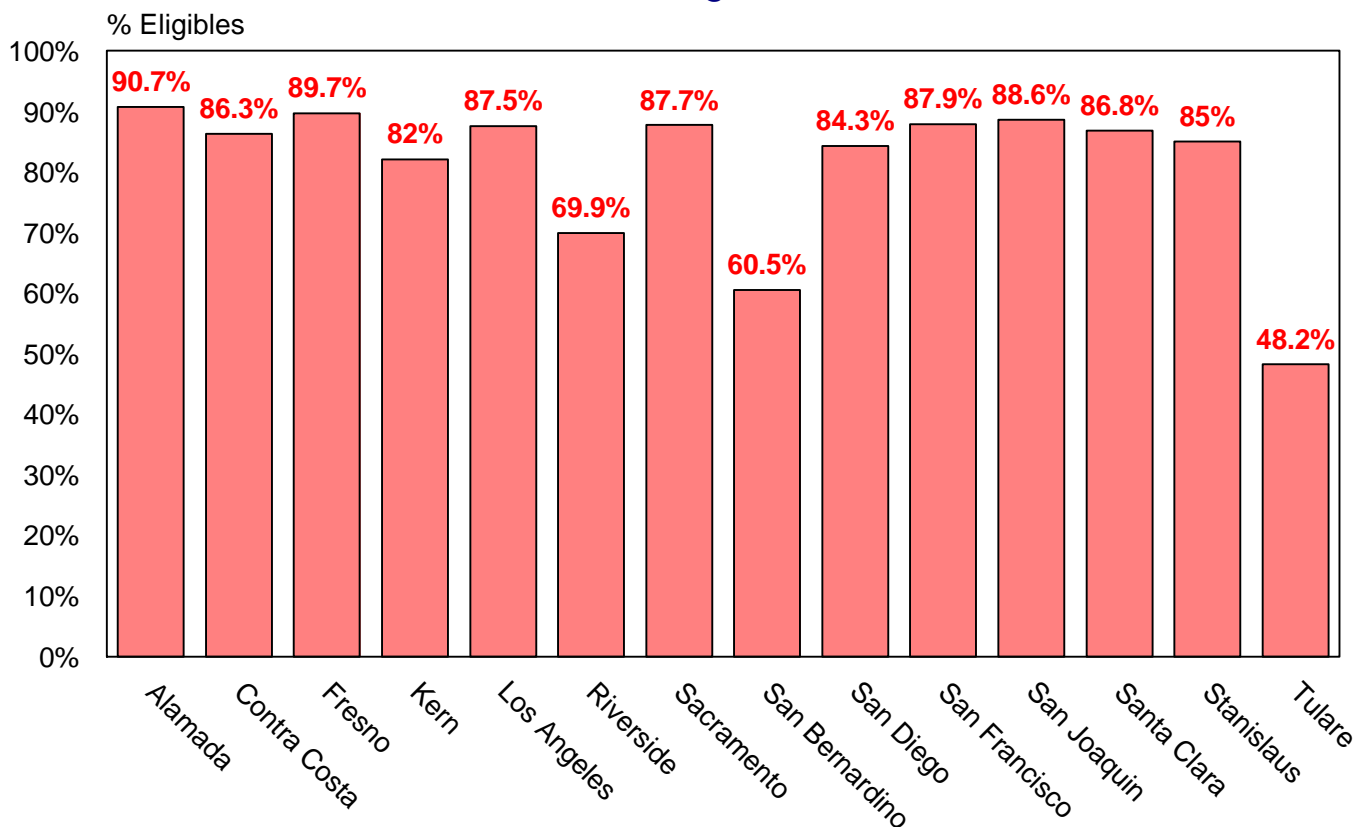


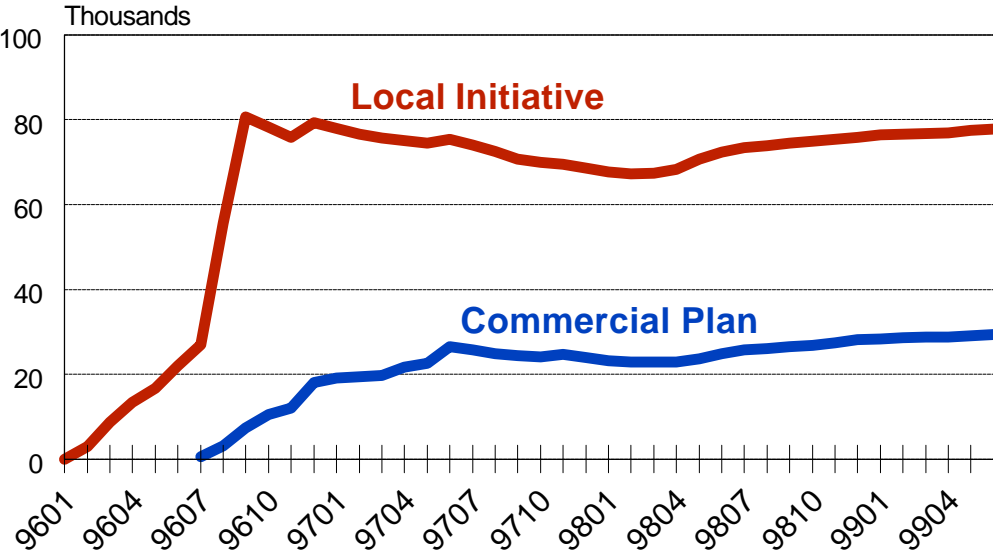
Table 1.7, Enrollment for Two-Plan Counties

With the exception of Riverside, San Bernardino, and Tulare, managed care in the Two-Plan model counties is substantially implemented as of July 1999. The following charts depict enrollment by county for the Commercial Plan vs. the Local Initiative since the start of implementation. As these show, in most cases, the Local Initiative has more Medi-Cal beneficiaries than the Commercial Plan. In fact, as of June 1999 on a statewide basis (excluding the Fresno model, which has two Commercial Plans and no Local Initiative), the Local Initiative plans have about two members for every one in the Commercial Plans. Some of this may partially be explained by the fact that the Local Initiative usually started up in each county before the Commercial Plan. However, in five counties (Los Angeles, San Francisco, Santa Clara, Stanislaus, and Tulare) the Local Initiative at one time had fewer enrollees, but as of June 1999 had more.

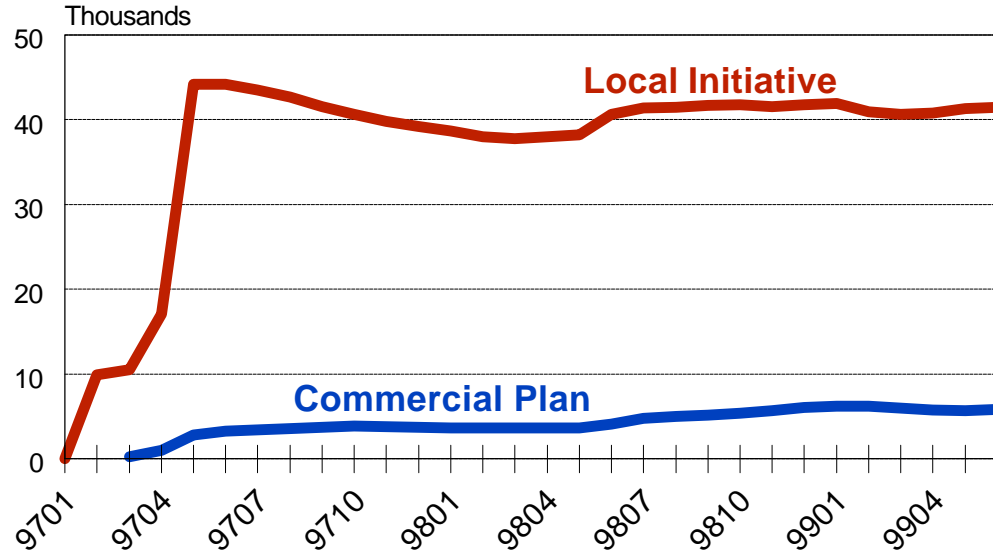
(Note: Eligible counts used here were taken from computer-based eligibility files using a six-month lag. Counts are slightly different from those shown in the Medi-Cal Managed Care Division's Monthly Enrollment Summary Report, usually because the computerized data base posts retroactive counts to the actual month of eligibility rather than rolling up all past activity at a point in time to the current report.)

Table 1.7, Enrollment for Two-Plan Counties (continued)

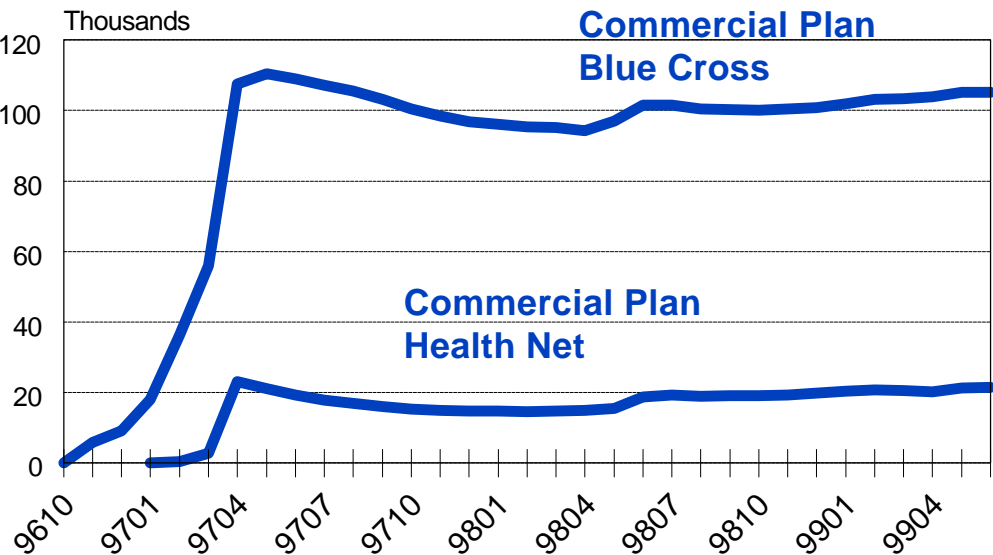
Alameda County



Contra Costa County



Fresno County



Kern County

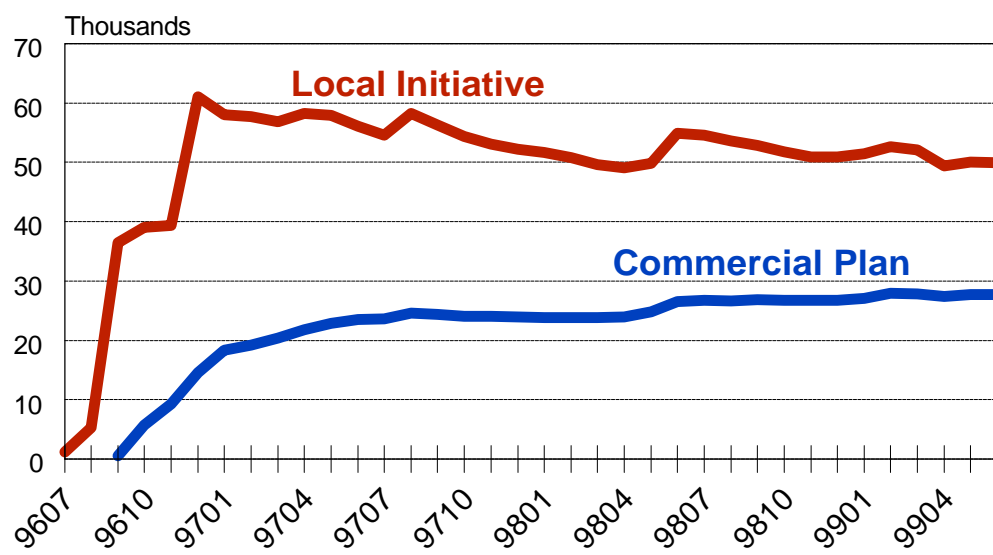
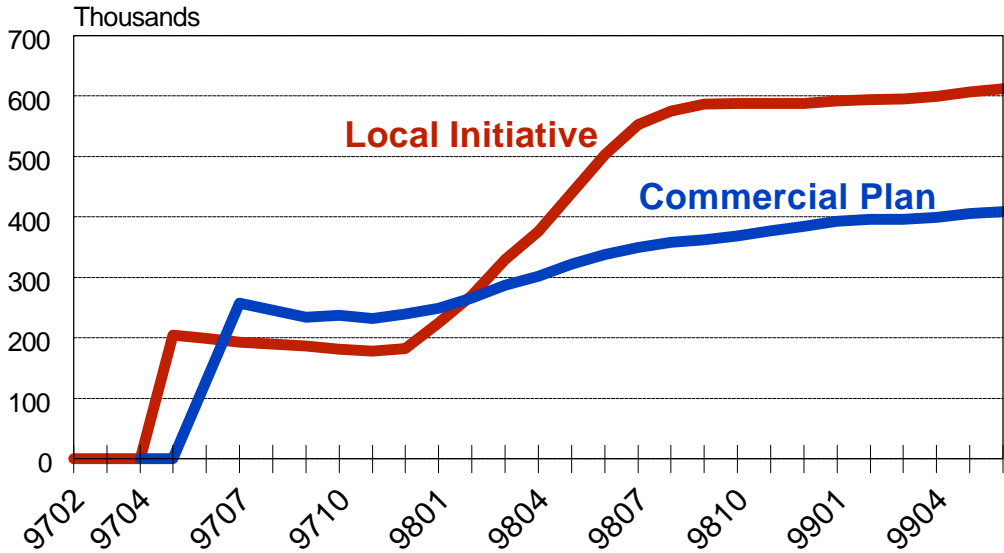
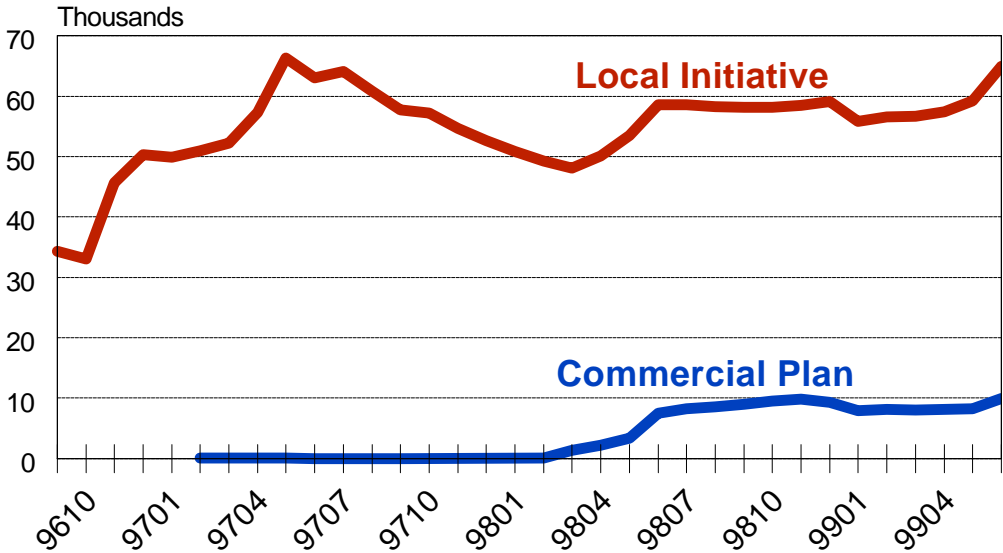


Table 1.7, Enrollment for Two-Plan Counties (continued)

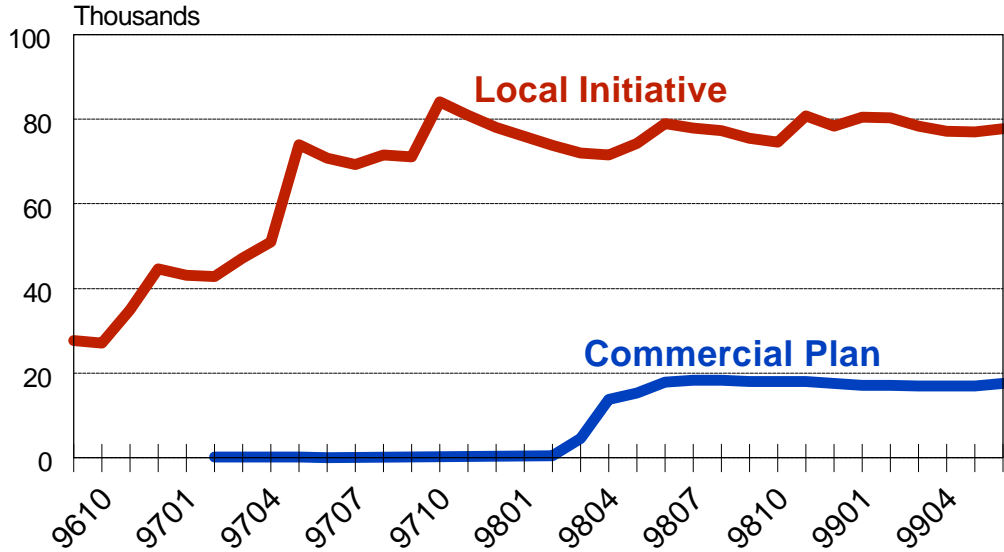
Los Angeles County



Riverside County



San Bernardino County



San Francisco County

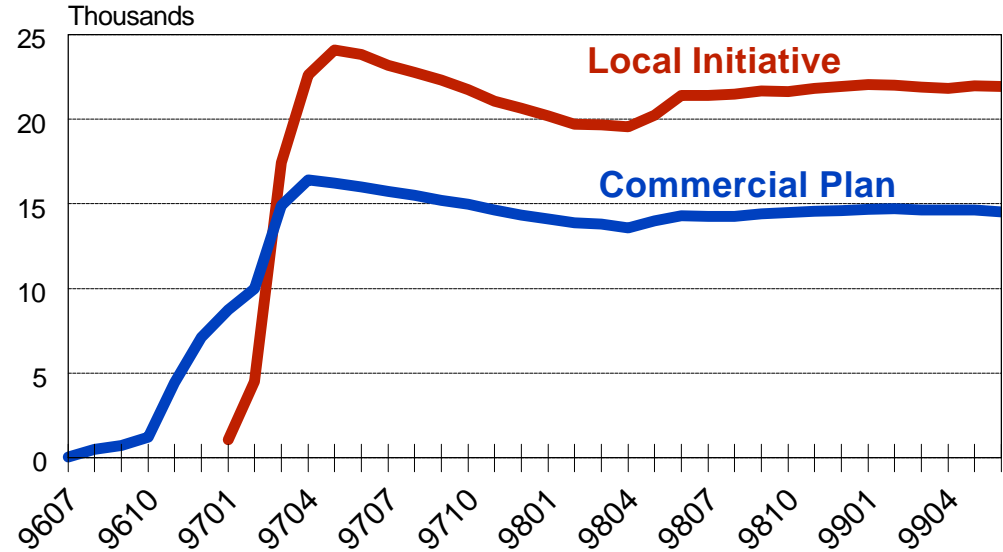
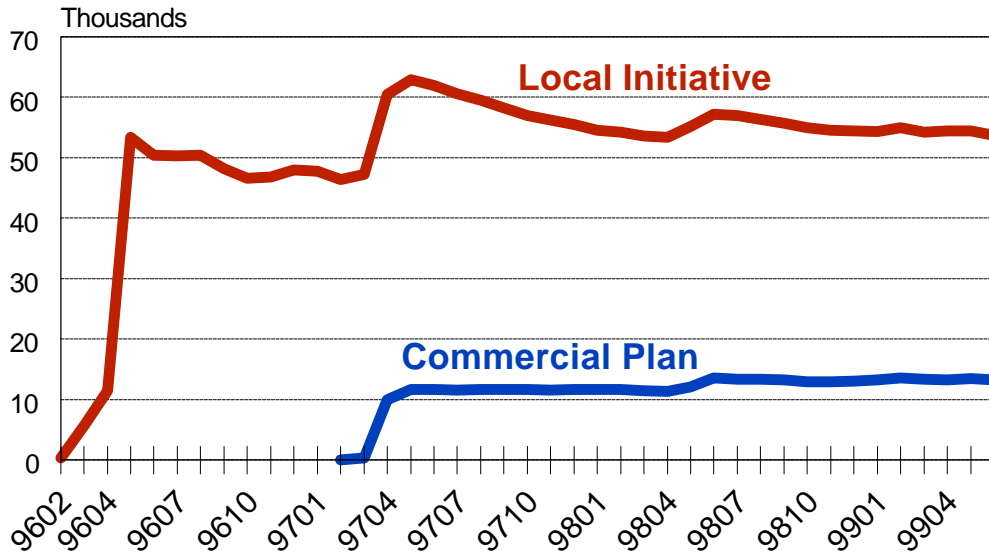
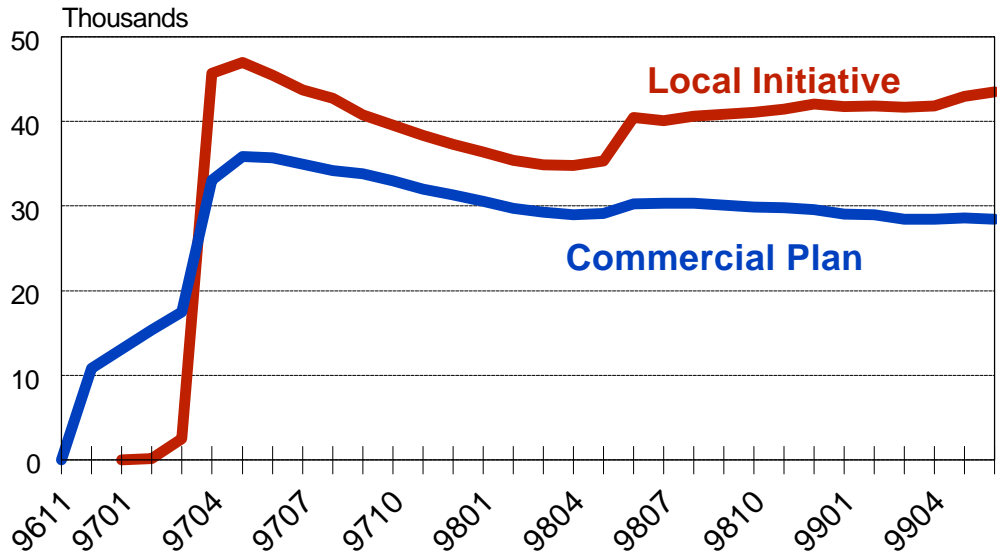


Table 1.7, Enrollment for Two-Plan Counties (continued)

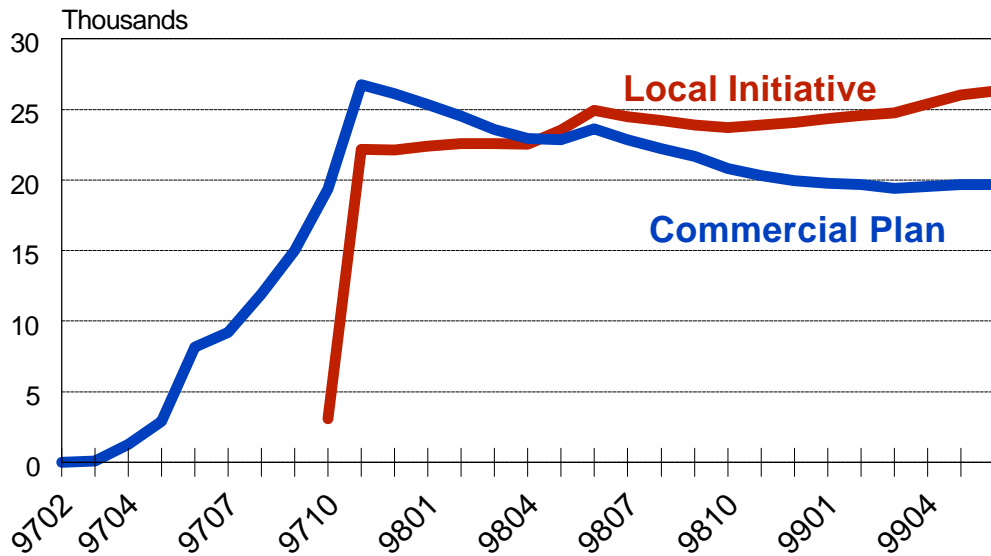
San Joaquin County



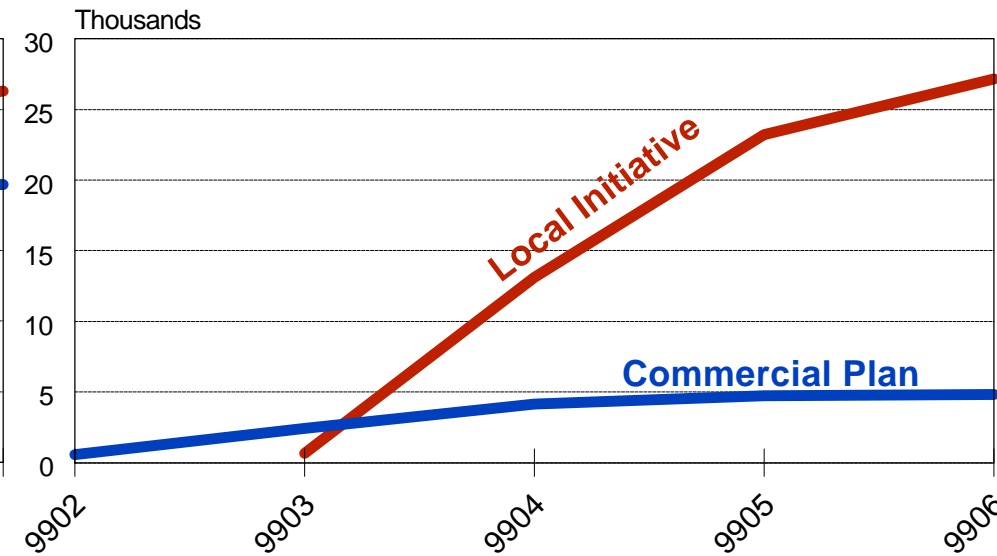
Santa Clara County



Stanislaus County



Tulare County



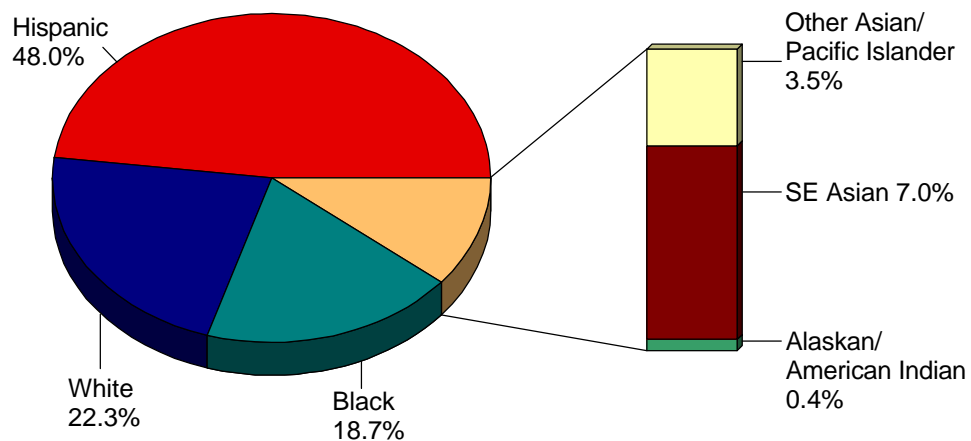
Section 2, Demographic Characteristics

Table 2.1, Breakout of Eligibles by Major Ethnic Groups

The following charts show a distribution of the Medi-Cal eligible population in managed care (GMC and Two-Plan) counties by major ethnic category. The first chart shows this breakout for the population considered Mandatory under the Two-Plan model, that is, primarily CalWorks, etc. The second chart covers those not in a GMC or Two-Plan Mandatory (CalWorks, etc.) aid category group.

Source of these data is the July 1999 month of eligibility Medi-Cal Eligibles File using a four-month lag.

Mandatory (CalWorks, etc.) Eligibles



Non-Mandatory (Non-CalWorks, etc.) Eligibles

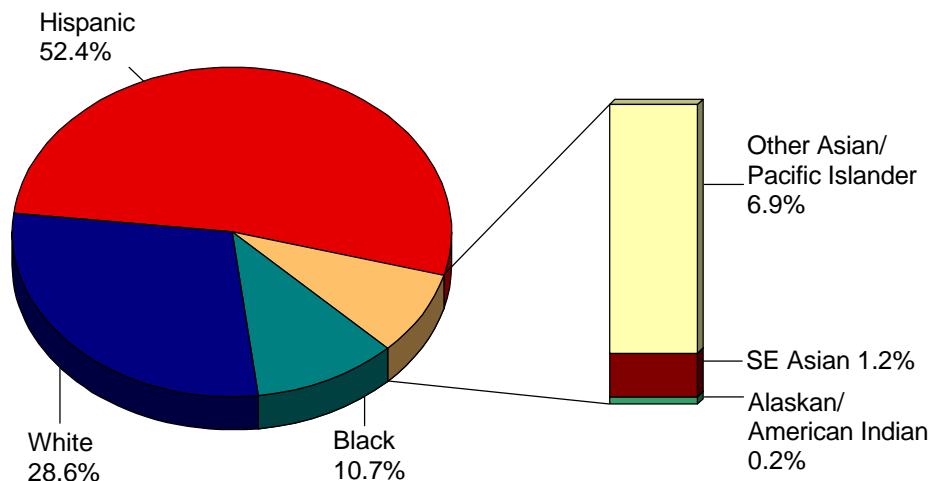
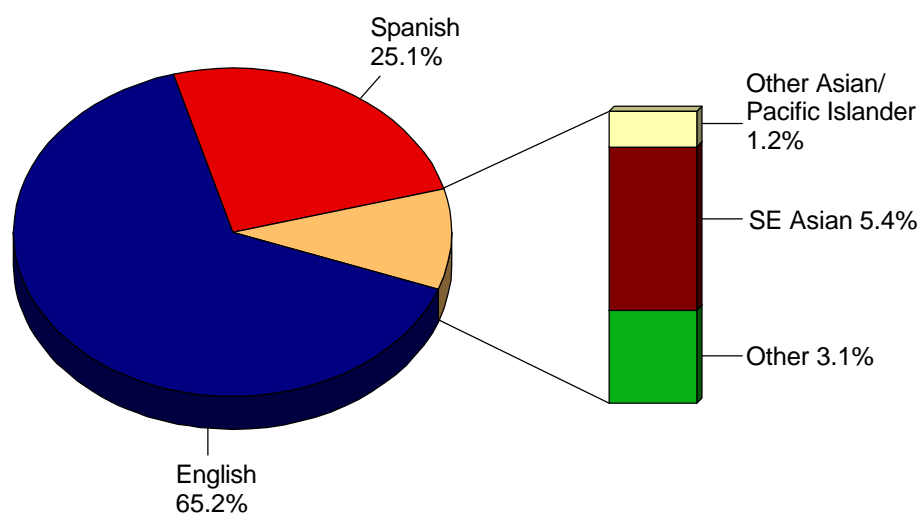


Table 2.2, Breakout of Eligibles by Major Language Category

The following charts show a distribution of the Medi-Cal eligible population in managed care (GMC and Two-Plan) counties by major language category. The first chart shows this breakout for the population considered Mandatory under the Two-Plan model, that is, primarily CalWorks, etc. The second chart covers those not in a GMC or Two-Plan Mandatory (CalWorks, etc.) aid category group.

Source of these data is the July 1999 month of eligibility Medi-Cal Eligibles File using a four-month lag.

Mandatory (CalWorks, etc.) Eligibles



Non-Mandatory (Non-CalWorks, etc.) Eligibles

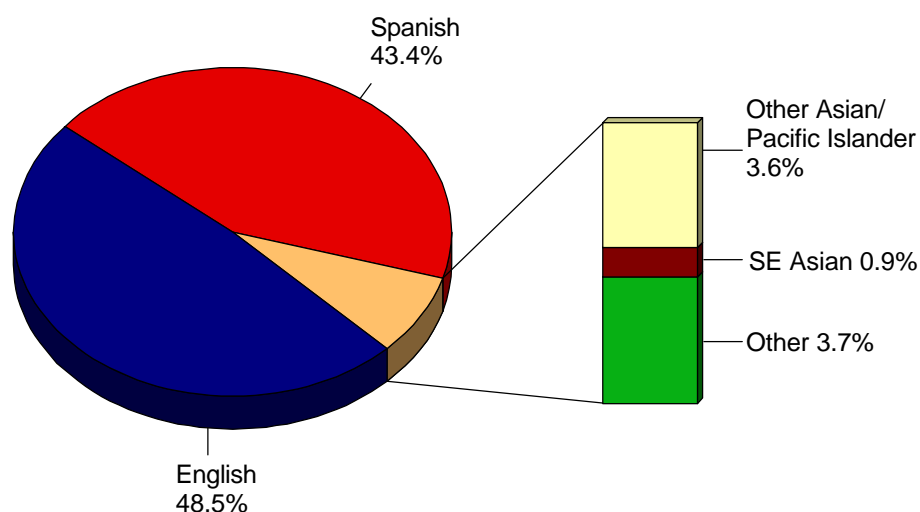


Table 2.3, Enrollment by Age and Gender for Two-Plan and GMC Counties

In understanding the medical needs of the Medi-Cal population, it is usually helpful to know their distribution by age, gender and coverage by fee-for-service vs. managed care. Charts by age and gender were provided in the [Managed Care Annual Statistical Report Published April 1999](#) (see Table 2.3). The charts below provide a breakout of those enrolled in managed care vs. FFS, by age and gender, for the Two-Plan and GMC counties for all aid codes. (Note: These data are from the July 1999 month of eligibility using a four-month lag; all ages are rounded off.)

The first chart illustrates that a low percentage (45%) of the kids up to twelve months of age residing in a Two-Plan/GMC county are in managed care. This is primarily due to the high rate of retroactive beneficiaries. As mentioned in [Table 1.6](#), beneficiaries who are retroactive are not put into these types of managed care plans. The chart also illustrates that the percent of those in a managed care plan remains stable for the female population, but rises briefly (to 69.1%) for eighteen year old males before declining to a more stable 40% for twenty-one year olds. This sudden rise and drop is explained by the different rates of decline for the mandatory vs. the non-mandatory males for the age groups eighteen to twenty year olds.

Percent of Medi-Cal Eligibles in Managed Care in Two-Plan and GMC Counties, by Age

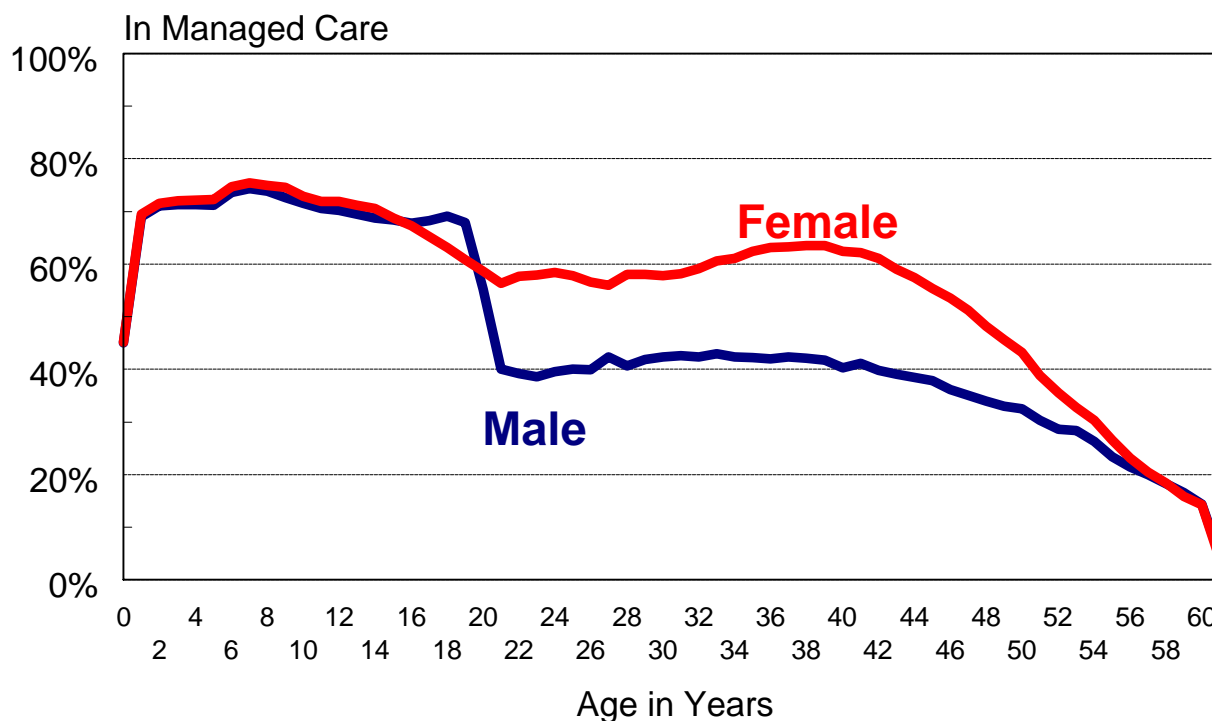
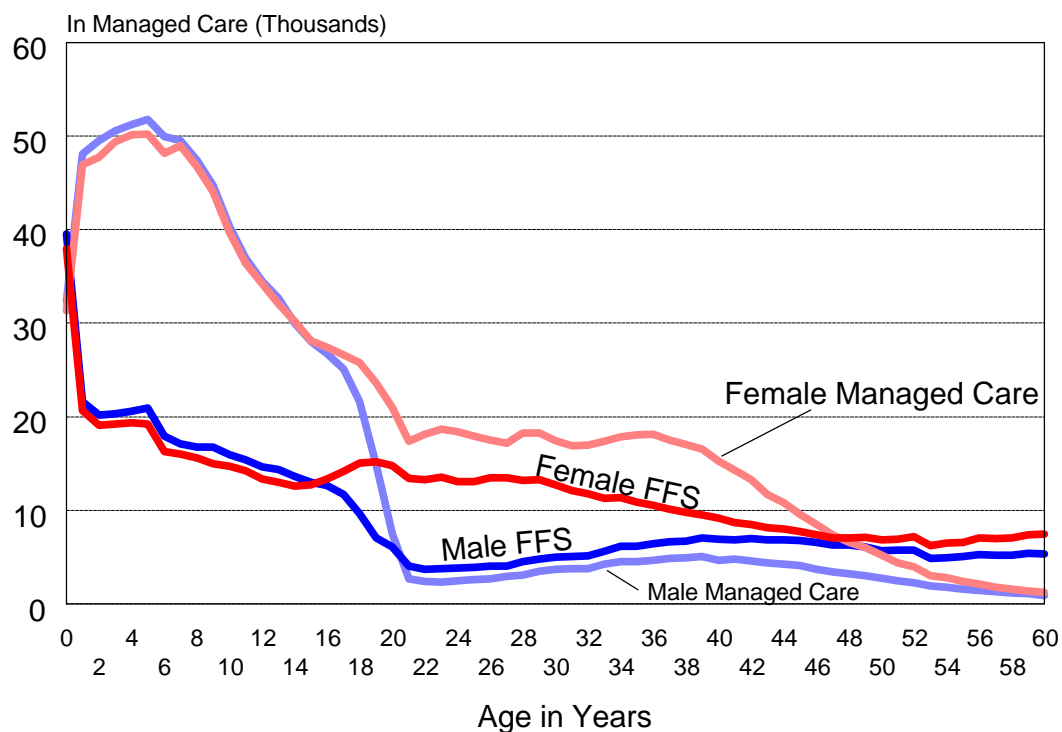


Table 2.3, Enrollment by Age and Gender for Two-Plan and GMC Counties (continued)

Number of Medi-Cal Eligibles in FFS vs. Managed Care in Two-Plan and GMC Counties, by Age



Section 3, Eligibility Continuity and Rate of New Eligibles

The length of time someone is on Medi-Cal is an important factor in the provision of medical services under managed care. The longer and more continuously a person is enrolled in a managed care plan, the easier it should be for a beneficiary to receive preventive and continuous care. Other benefits include the development of a closer relationship between the primary care physician and the beneficiary, and less administrative cost to the plan. One way to measure duration of eligibility is to determine how long individual beneficiaries are continuously Medi-Cal eligible. [Tables 3.1](#) and [3.2](#) provide rates of continuous eligibility for a recent period of time, without regard to a person's pre-existing eligibility.

This "continuity of eligibility" methodology was then applied to the mandatory aid category population for those counties that had implemented GMC and Two-Plan managed care plans. Separate rates were developed for all of those eligibles who remained enrolled in a managed care plan; these rates are shown in [Table 3.3](#).

Another useful measure of the stability of the Medi-Cal population in terms of eligibility is the rate at which new eligibles get on Medi-Cal. One measure of this is the number of eligibles moving from ineligibility to eligibility status, expressed as a percent of all eligibles. This rate was derived for all eligibles as well as just the managed care mandatory aid category population, and is depicted in [Tables 3.4](#) and [3.5](#).

Note: The information used to construct [Tables 3.1](#) through [3.3](#) were derived from a longitudinal data base for a five percent sample of all Medi-Cal beneficiaries, created and maintained by the Medical Care Statistics Section.

Table 3.1, Continuity of Eligibility in Aggregate

The following chart shows how long a beneficiary would tend to remain eligible for Medi-Cal over a three-year period. The chart reflects eligibility trends as they existed during CY96 through CY98.

To establish the rates shown below, each beneficiary in our database was tracked for thirty-six months, regardless of their eligibility status in the month immediately preceding the period. Any break in eligibility would drop an eligible from the curve at that point. (Studies have shown only a slight difference in the percent continuously eligible when a one-month break is allowed in the definition.)

The curve labeled “Aggregate” shows the rate at which a person who was eligible for Medi-Cal in the first month is likely to remain on Medi-Cal each month for up to thirty-six months. The chart shows that 60% of this population will likely still be on Medi-Cal after the first year, 47% after two years, and 40% after three. If this population were subsumed into eight relatively homogenous (in terms of eligibility) groups, the rate of continuous eligibility for all these beneficiaries staying within their assigned group is shown in the chart as “Aggregate – All Groups.” (The difference between the curves is the population who were continuously eligible, but went from one eligibility group to another.) Note that the rates shown here are significantly lower than for one year earlier; (For the year earlier rates, see the [Managed Care Annual Statistical Report published April 1999.](#))

Continuous Eligibility

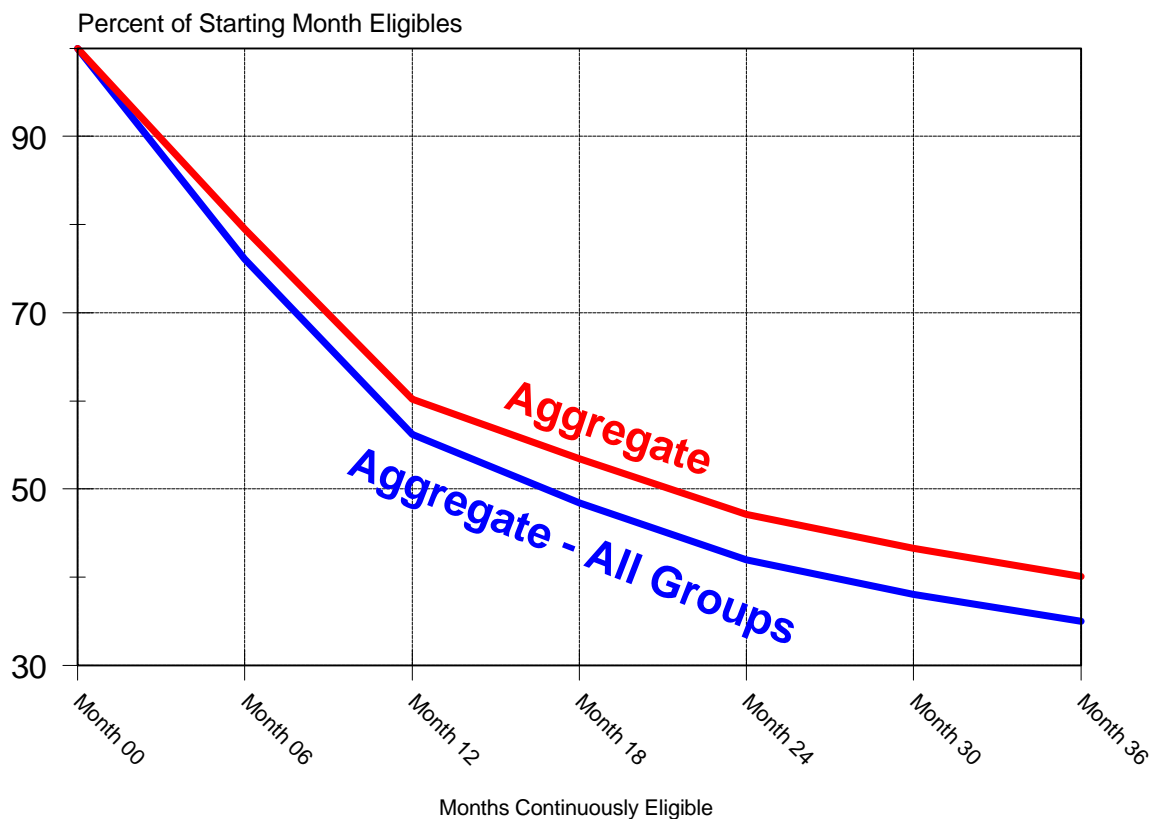


Table 3.2, Continuity of Eligibility by Major Aid Category Group

The following chart is similar to [Table 3.1](#), except that eligibles were subsumed into distinct eligibility groups. Each curve represents those eligibles who continuously belonged to an assigned group for the months shown. If a Medi-Cal eligible either ceased being eligible, or changes to another aid category within this time period, they are excluded from the curve at that point.

It is important to note that this table includes anyone who was eligible the first month of this thirty-six month time frame without regard to their eligibility status in Month 00. A subset of this population is one in which persons were not on Medi-Cal in Month 00, the month prior to the period being considered here. For those interested in this topic, please refer to [Table 3.3, Continuity of Eligibility for AFDC – Cash Grant](#), the Managed Care Annual Statistical Report published April 1999.

The major groups shown in the chart are: 1. SSI/SSP; 2. Long Term Care; 3. Cal-Works; 4. Medi-Cal only, Aged Blind, Disabled, no share of cost; 6. Share of cost; 7. OBRA; 8. Miscellaneous. (For a listing of the aid categories making up each of these groupings, refer to the [Appendix, Table A.2.](#))

Continuous Eligibility by Group

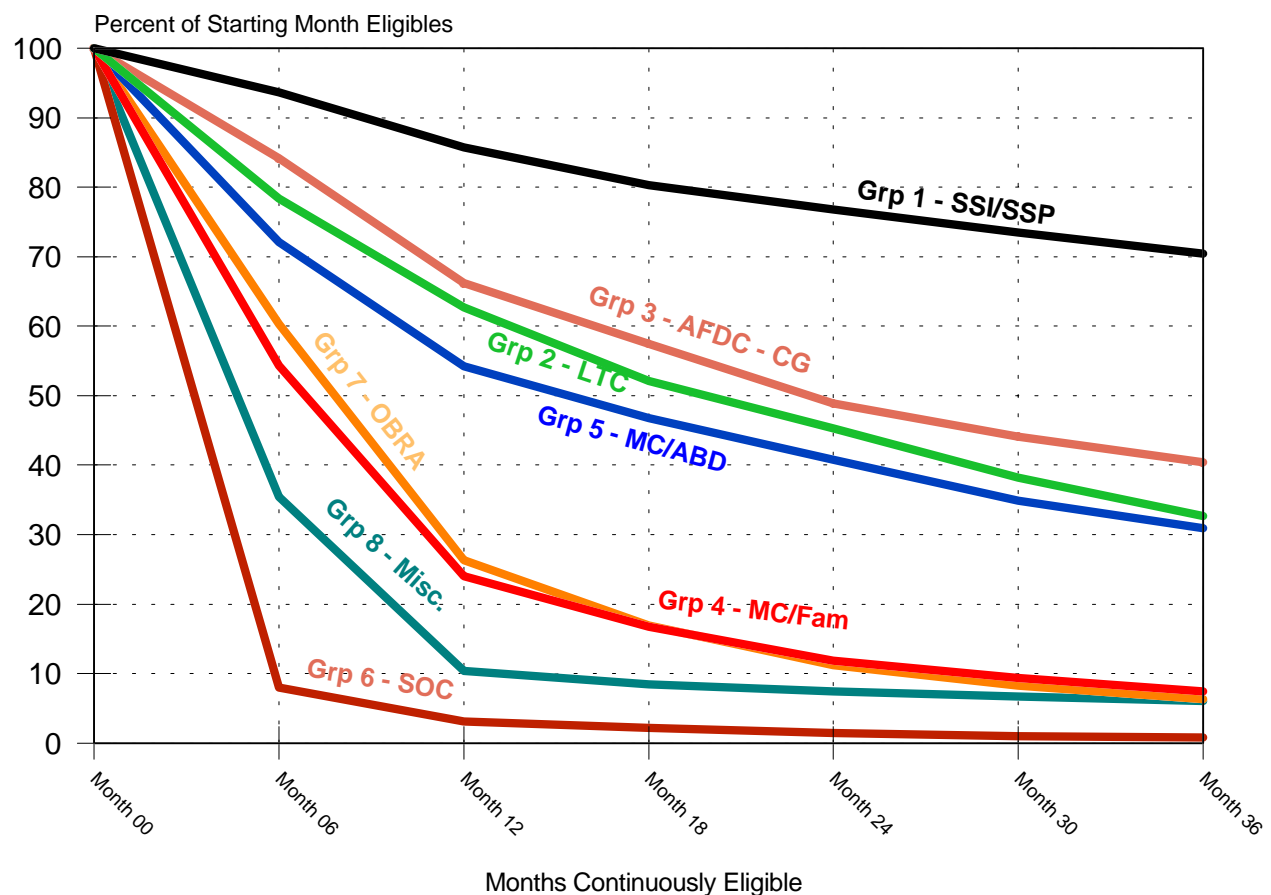


Table 3.3, Continuity of Eligibility for Mandatory Aid Codes, Eligible vs. Enrolled in Plan

The rate at which persons on Medi-Cal will be continuously eligible is slightly higher than for the population enrolled continuously in the same managed care plan. The difference in the rates may be attributable to such factors as switching enrollment from one plan to another or obtaining a medical exemption to obtain services under fee-for-service. The following chart shows these rates for the period July 98 through December 98 for fully implemented Two-Plan counties. (The methodology applied here is similar to that used for [Table 3.2](#); the rate is for a population of eligibles who may or may not have been eligible prior to July 98 within the same managed care counties used to create the enrollment rate.)

The rates for this period are higher than those for the same period in CY97. Although not shown, an analysis of this rate was done separately for all local initiative plans vs. all commercial plans, but there was no significant difference.

Rate of Eligibility vs. Two-Plan Enrollment Mandatory Aid Codes

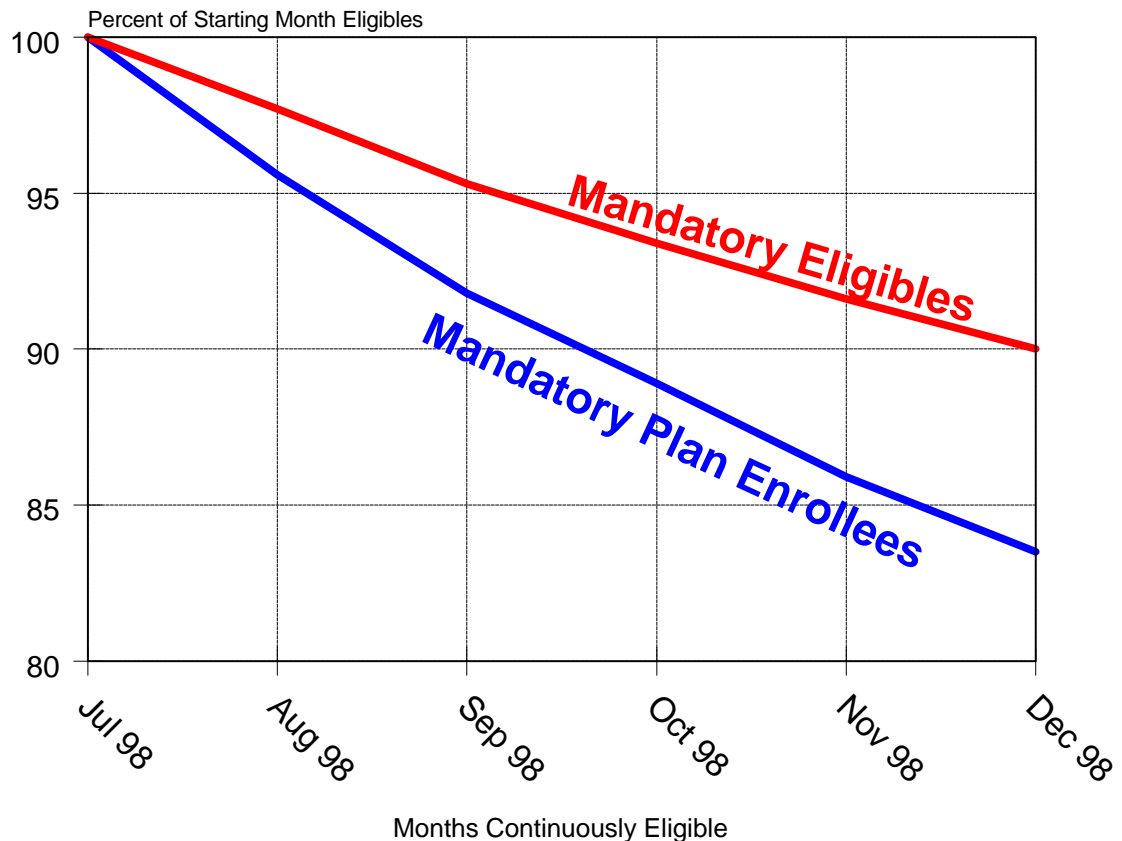


Table 3.4, Rate of “Six-Month” New Beneficiaries on Medi-Cal

As with continuity of eligibility, the rate at which beneficiaries become eligible for Medi-Cal provides some measure of the turnover of this population. As mentioned above, this in turn can have a direct impact on the quality of care provided under managed care. There are two approaches to looking at this turnover issue: one is to consider just those who are relatively new to Medi-Cal, the other is to look at those with only one month of ineligibility. The difference should be an approximation of those intermittently, that is, not continuously, enrolled in Medi-Cal.

The following chart shows the rate at which beneficiaries become eligible after being ineligible (not on Medi-Cal) for six months, i.e., the “new to Medi-Cal population.” The percentages shown in this table were derived by first calculating a denominator of a count of eligibles for the months February, May, August, and November for the calendar years 1993 through 1998. A subset of this population, those ineligible the previous six months, was used to calculate a percent or rate of those “new” to Medi-Cal. The same methodology was used to develop a rate for the “mandatory” population, those most likely to be in a managed care plan in Two-Plan Model and GMC counties. (Note: To provide comparability of data, the same aid codes are defined as mandatory for all years, even though this definition has changed slightly over this period. For instance, using a current definition of mandatory aid codes, the rate is marginally higher.)

As information from this chart shows, the overall rate of new persons coming onto Medi-Cal dropped significantly from CY93 to CY97, then rose slightly in CY98. It is significant that the number of those who were new from CY97 to CY98 (the nominator) changed little, but the number of eligibles on Medi-Cal (the denominator) has decreased significantly, thereby accounting for most of the increased rate of “New” eligibles. (See [Excel Table 3.4](#), which accompanies this report.) Evidently, the same factor(s) causing the total number of eligibles to decrease was not acting on the “New” eligibles with equal and concurrent effect.)

Rate of New Medi-Cal Eligibles after six-months of being ineligible

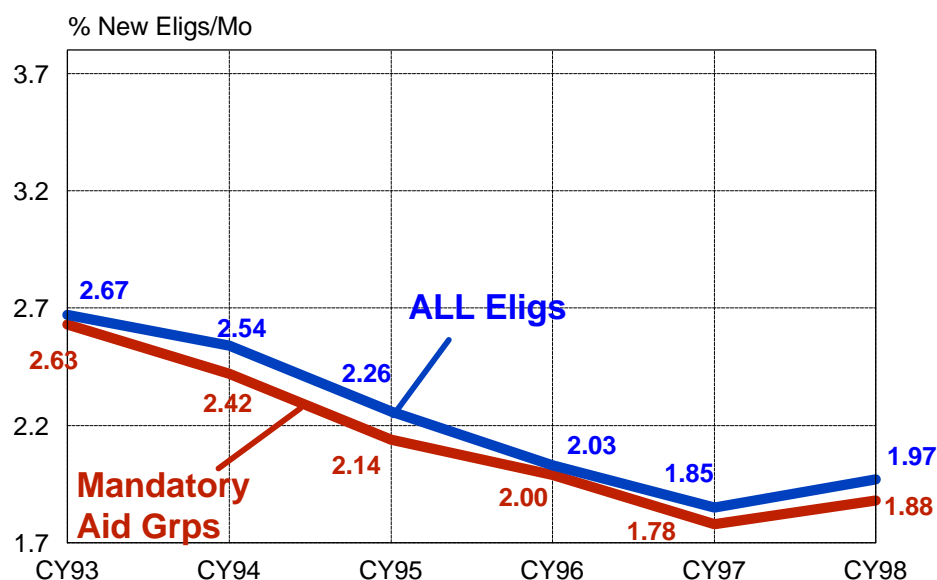
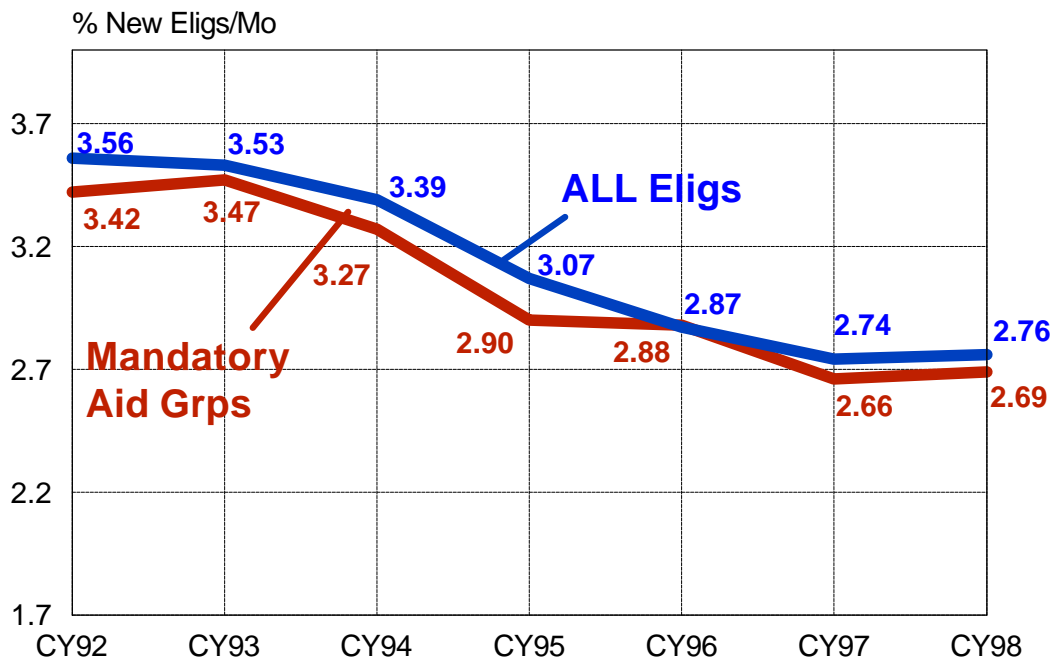


Table 3.5, Rate of “One-Month” New Beneficiaries on Medi-Cal

As the following chart indicates, when the definition of “new eligible” is relaxed from six months of ineligibility to one month, the percentages increase substantially. It is interesting to note that the rate of “One-Month” new eligibles is virtually the same from CY97 to CY98, unlike the “Six-Month” new eligibles rate, which increased.

Rate of New Medi-Cal Eligibles after one-month of being ineligible



Appendices

- [Appendix, Table A.1,](#) List of Aid Categories by Managed Care Model and Type of Membership Status
- [Appendix, Table A.2,](#) List of Aid Categories Used for Continuous Eligibility Charts in [Section 3](#)

Appendix, Table A.1, List of Aid Categories by Managed Care Model and Type of Membership Status

The following table provides a list by aid categories, and which are considered mandatory (M), vs. voluntary (V), vs. other (o) (can't join) for each plan model. (Note: This table was current as of July 1999. For a current table, contact the DHS Medi-Cal Managed Care Division.)

Aid Cat.	COHS					GMC		Two-Plan	PHP/PCCM
	Napa & Solano	Orange	San Mateo	Santa Barbara	Santa Cruz	Sacramento	San Diego		
01	M	M	M	M	M	o	M	M	V
02	M	M	M	M	M	o	M	M	V
03	M	M	M	M	M	V	V	V	V
04	M	M	M	M	M	V	V	V	V
08	M	M	M	M	M	o	M	M	V
10	M	M	M	M	M	V	V	V	V
13	M	M	M	M	M	o	o	o	o
14	M	M	M	M	M	V	V	V	V
16	M	M	M	M	M	V	V	V	V
17	M	M	M	M	M	o	o	o	o
18	M	M	M	M	M	V	V	V	V
0A	M	M	M	M	M	o	M	M	V
1A	M	M	M	M	M	V	V	V	V
1D	M	M	M	M	M	o	o	o	o
1J	M	M	M	M	M	o	o	o	o
1M	M	M	M	M	M	o	o	o	o
1N	M	M	M	M	M	o	o	o	o
1T	M	M	M	M	M	o	o	o	o
20	M	M	M	M	M	V	V	V	V
23	M	M	M	M	M	o	o	o	o
24	M	M	M	M	M	V	V	V	V
26	M	M	M	M	M	V	V	V	V
27	M	M	M	M	M	o	o	o	o
28	M	M	M	M	M	V	V	V	V
2D	M	M	M	M	M	o	o	o	o
30	M	M	M	M	M	M	M	M	V
32	M	M	M	M	M	M	M	M	V
33	M	M	M	M	M	M	M	M	V
34	M	M	M	M	M	M	M	M	V
35	M	M	M	M	M	M	M	M	V
36	M	M	M	M	M	V	V	V	V
37	M	M	M	M	M	o	o	o	o
38	M	M	M	M	M	M	M	M	V
39	M	M	M	M	M	M	M	M	V
3A	M	M	M	M	M	M	M	M	V
3C	M	M	M	M	M	M	M	M	V
3D	M	M	M	M	M	o	o	o	o
3E	M	M	M	M	M	M	M	M	V
3F	M	M	M	M	M	o	o	o	o
3G	M	M	M	M	M	M	M	M	V
3H	M	M	M	M	M	M	M	M	V
3L	M	M	M	M	M	M	M	M	V
3M	M	M	M	M	M	M	M	M	V
3N	M	M	M	M	M	M	M	M	V
3P	M	M	M	M	M	M	M	M	V
3R	M	M	M	M	M	M	M	M	V
3T	M	M	M	M	M	o	o	o	o
3U	M	M	M	M	M	M	M	M	V
3V	M	M	M	M	M	o	o	o	o



Appendix, Table A.1, List of Aid Categories by Managed Care Model and Type of Membership Status (continued)

Aid Cat.	COHS					GMC		Two-Plan	PHP/PCCM
	Napa & Solano	Orange	San Mateo	Santa Barbara	Santa Cruz	Sacramento	San Diego		
40	M	M	M	M	M	V	V	V	V
42	M	M	M	M	M	V	V	V	V
44	M	M	M	M	M	○	○	○	○
45	M	M	M	M	M	V	V	V	V
47	M	M	M	M	M	M	M	V	V
48	M	M	M	M	M	○	○	○	○
4C	M	M	M	M	M	V	V	V	V
4F	M	M	M	M	M	V	V	V	V
4G	M	M	M	M	M	V	V	V	V
4K	M	M	M	M	M	V	V	V	V
53	M	○	M	M	M	○	○	○	○
54	M	M	M	M	M	M	M	M	V
55	M	○	M	○	○	○	○	○	○
58	M	○	M	○	○	○	○	○	○
59	M	M	M	M	M	M	M	M	V
5F	M	○	M	○	○	○	○	○	○
5G	M	○	M	M	○	○	○	○	○
5K	M	M	M	○	M	V	V	V	V
5N	M	○	○	○	○	○	○	○	○
5T	M	M	M	M	M	○	○	○	○
5W	M	M	M	M	M	○	○	○	○
5X	M	M	M	M	M	M	M	M	V
5Y	M	M	M	M	M	○	○	○	○
60	M	M	M	M	M	V	V	V	V
63	M	M	M	M	M	○	○	○	○
64	M	M	M	M	M	V	V	V	V
65	M	M	M	M	M	○	○	○	○
66	M	M	M	M	M	V	V	V	V
67	M	M	M	M	M	○	○	○	○
68	M	M	M	M	M	V	V	V	V
69	M	M	M	M	M	○	○	○	○
6A	M	M	M	M	M	V	V	V	V
6C	M	M	M	M	M	V	V	V	V
6D	M	M	M	M	M	○	○	○	○
6N	M	M	M	M	M	V	V	V	V
6P	M	M	M	M	M	V	V	V	V
6R	M	M	M	M	M	V	V	V	V
6T	M	M	M	M	M	○	○	○	○
6V	M	M	M	M	M	V	V	V	V
6W	M	M	M	M	M	○	○	○	○
6X	M	M	M	M	M	○	○	○	○
6Y	M	M	M	M	M	○	○	○	○
72	M	M	M	M	M	M	M	V	V
74	M	M	M	M	M	○	○	○	○
7A	M	M	M	M	M	M	M	V	V
7C	M	M	M	M	M	○	○	○	○
7E	M	M	M	M	M	○	○	○	○
7X	M	M	M	M	M	M	M	M	V
81	M	M	M	M	M	○	○	○	○
82	M	M	M	M	M	M	M	M	V
83	M	M	M	M	M	○	○	○	○
86	M	M	M	M	M	V	V	V	V
87	M	M	M	M	M	○	○	○	○
8G	M	M	M	M	M	○	○	○	○
8N	M	M	M	M	M	○	○	○	○
8P	M	M	M	M	M	M	M	V	V
8R	M	M	M	M	M	M	M	V	V
8T	M	M	M	M	M	○	○	○	○



Appendix, Table A.2, List of Aid Categories Used For Section 3

<u>Major Grouping</u> <u>Elig Study</u>	<u>CIDCUM</u>	<u>Minor</u> <u>Grouping</u>	<u>Aid Categories</u>
1. SSI/SSP	CASH GRANT	AB	20
1. SSI/SSP	CASH GRANT	ATD	60
1. SSI/SSP	CASH GRANT	OAS	10
1. SSI/SSP	IN HOME SUPPORT	AB	28
1. SSI/SSP	IN HOME SUPPORT	ATD	68
1. SSI/SSP	IN HOME SUPPORT	OAS	18
2. Long Term Care	MI ADULT	-----	53
2. Long Term Care	MN-LONG TERM NG	AB	23
2. Long Term Care	MN-LONG TERM NG	ATD	63
2. Long Term Care	MN-LONG TERM NG	OAS	13
3. Cal-Works-Cash Grant	CASH GRANT	Cal-Works	30, 32, 33, 35, 38, 40, 42, 3A, 3C, 3P, 3R, 3G, 3H, 3E, 3L, 3M, 3U, 4C
4. Medi-Cal only, Families, No SOC	TRANSITIONAL	Cal-Works	39, 54, 59, 3T, 5T, 5W, 5X, 5Y
4. Medi-Cal only, Families, No SOC	CHILDREN	-----	72, 74, 7A, 7C, 5M, 8N, 8P, 8T
4. Medi-Cal only, Families, No SOC	INFANTS	-----	07, 47, 69, 79
4. Medi-Cal only, Families, No SOC	MI ADULT	-----	86
4. Medi-Cal only, Families, No SOC	MI YOUTH	-----	45
4. Medi-Cal only, Families, No SOC	MI YOUTH	-----	4K
4. Medi-Cal only, Families, No SOC	MI YOUTH	-----	04
4. Medi-Cal only, Families, No SOC	MI YOUTH	-----	5K
4. Medi-Cal only, Families, No SOC	MI YOUTH	-----	03
4. Medi-Cal only, Families, No SOC	MI YOUTH	-----	82
4. Medi-Cal only, Families, No SOC	MINOR CONSENT	-----	7M, 7P, 7R, 7N
4. Medi-Cal only, Families, No SOC	MN - NO SOC	Cal-Works	34, 3N, 3V
4. Medi-Cal only, Families, No SOC	WOMEN	-----	44, 48, 49, 70, 75, 76, 7F, 7G
5. Medi-Cal only, ABD, No SOC	MN - NO SOC	AB	24
5. Medi-Cal only, ABD, No SOC	MN - NO SOC	ATD	64, 6V, 6X
5. Medi-Cal only, ABD, No SOC	MN - NO SOC	OAS	14
5. Medi-Cal only, ABD, No SOC	TITLE II DISRGRD	AB	26, 6A
5. Medi-Cal only, ABD, No SOC	TITLE II DISRGRD	ATD	36, 66, 6C
5. Medi-Cal only, ABD, No SOC	TITLE II DISRGRD	OAS	15, 16
6. Share of Cost	MI ADULT	-----	87
6. Share of Cost	MI YOUTH	-----	83
6. Share of Cost	MN - SHR OF COST	AB	27
6. Share of Cost	MN - SHR OF COST	Cal-Works	37
6. Share of Cost	MN - SHR OF COST	ATD	65, 67, 6Y, 6W
6. Share of Cost	MN - SHR OF COST	OAS	17
7. OBRA	OBRA ALIENS	-----	55, 58, 5F, 5G, 5H
8. Miscellaneous	ICRA ALIENS	-----	51, 52, 56, 57
8. Miscellaneous	MI ADULT	-----	81
8. Miscellaneous	PARENTERAL NUTRI	-----	73
8. Miscellaneous	QMB-ONLY	-----	80, 8G
8. Miscellaneous	REFUGEES	-----	01, 0A, 02, 08
8. Miscellaneous	RENAL DIALYSIS	-----	71
8. Miscellaneous	TB PROGRAM	-----	7H

